Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SURGERY CENTER OF ARLINGTON 2400 MATLOCK ARLINGTON, TX 76015	MFDR Tracking #: M4-09-7917-01
Respondent Name and Box #: ACE AMERICAN INSURANCE CO. Rep Box # 15	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "The attached claim was under paid. We are disputing the allowed amount of CPT #27340. This claim has been appealed two times and no additional payment was made. The correct fee schedule allowed amount for this procedure is $2,037.53."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $619.10
3. CMS 1500
4. EOB's
5. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Billing paid appropriately per code review standards." "System vendor reviewing for any add'l pymts which may be due will provide follow-up asap."

Principal Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10/16/08	27340-LT	W1, 193	1-3	$619.10
Total /Due:				$619.10

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective 08/31/08, set out the reimbursement guidelines.

1. The disputed services were denied or reduced reimbursement based upon:
   - "W1-Workers Compensation State Fee Schedule Adjustment. Payment based on CMS ASC Facility payment guidelines. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time; and
   - 193-Original payment decision is being maintained. Final action. In accordance with Rule 133.250(G): 'A Health Care Provider shall not resubmit a request for reconsideration after the carrier has taken final action on the request."
2. The 10/16/08 operative report indicates the claimant underwent the following:
   - "Resection of left knee prepatellar bursa."
3. Per Rule 134.402(f) reimbursement for non-device intensive procedure for CPT code 27340-LT is:

   The national reimbursement is found in the Addendum AA ASC Covered Surgical Procedures for CY 2008 = $880.55. The national reimbursement is divided by 2 = $440.28 ($880.55/2).

   This number X City Conversion Factor/CMS Wage Index for Arlington $440.28 X 0.9693 = $426.76.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $426.76 + $440.28 = $867.04.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $867.04 X 235% = $2,037.54.

   The MAR for CPT code 27340-LT is $2,037.54. The insurance carrier paid $1,418.43. The difference between amount due and paid equals $619.10.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §134.1
28 Texas Administrative Code §134.402 effective 08/31/08

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of **$619.10** plus applicable accrued interest per Division Rule §134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	August 4, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.